



HMI Seminar on Tariff Determination

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Agenda



1 | Challenges in the current environment



2 | Key observations



3 | Recommendations



Challenges in the current environment



- PMB regulations requiring funders to pay in full creates an unknown and significant liability for schemes
- Structure of PMBs and requirement to cover at cost impedes price negotiation and contributes to inflation drivers
- Health professional market is highly fragmented, limiting funders ability to enter into bilateral negotiations. Current competition law constraints apply as well.
- HPCSA rules prohibit employment of doctors limiting the potential of alternatives to fee for service reimbursement
- Third party payer problem, with consumer asymmetry of information, resulting in increased utilisation of healthcare services driven by both supply and demand side factors
- Lack of organised forums prevents collaboration on critical coding updates



Key observations (1 of 2)

- 1** **Utilisation rather than prices is the major driver of medical claims inflation**
 - Price regulation will therefore not be an effective mechanism for controlling overall claims inflation
 - HMI has acknowledged that price regulation will not mitigate against high levels of contribution inflation faced by medical scheme members

- 2** **Existing process of tariff negotiation/setting have several advantages**
 - Pro competitive in provider, scheme and administrator markets
 - Stimulates innovation in procurement, contracting, network design etc
 - DH tariff negotiation processes are rigorous, and increasingly focus on utilisation and quality, as well as price. Other administrators are developing or already have similar capacity

- 3** **Critical to distinguish corporate providers (hospitals, pathology) from other providers (health professionals) due to very different market and competition dynamics**
 - Negative impact of current tariff and coding processes more apparent in individual professional market than in corporate provider market. Interventions, if any, should focus on individual provider markets
 - Interventions in corporate markets will reduce competition and harm consumers



Key observations (2 of 2)

4 A shift to coordinated bargaining or price regulation will create significant risks

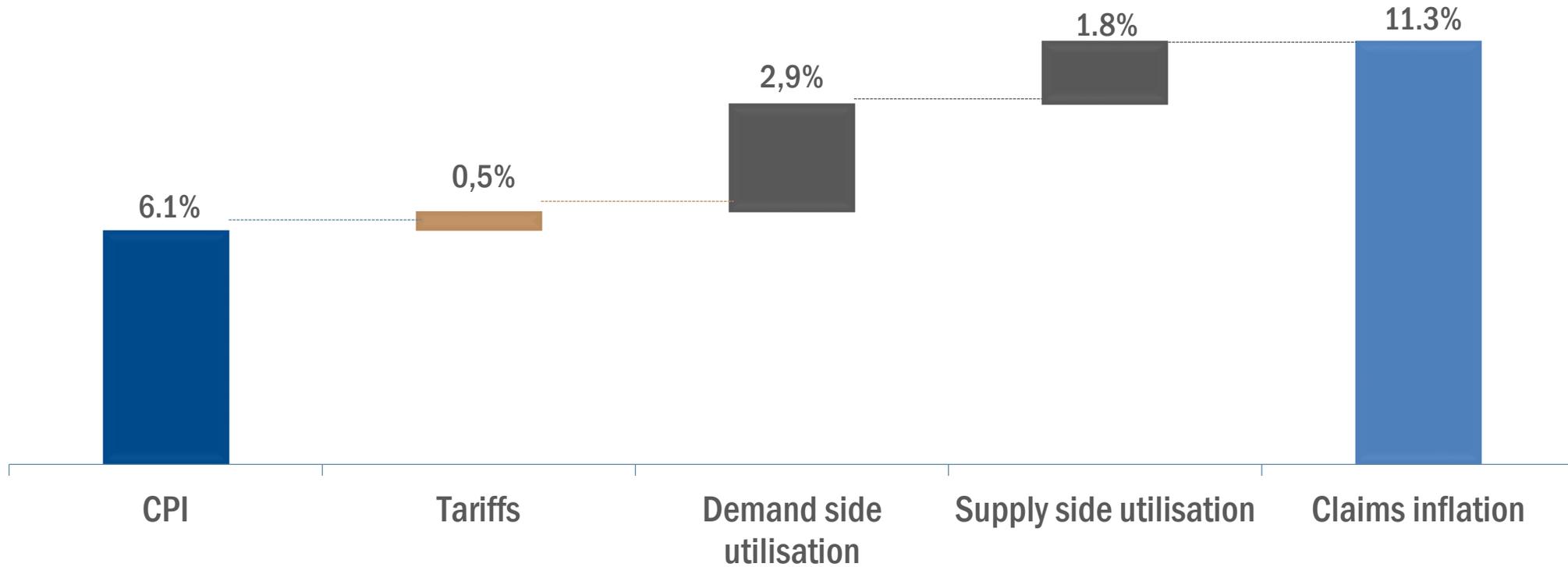
- Reduced competition due to supplier coordination/collusion
- Reduced innovation
- Potential for poor governance and/or lack of technical capability – with risks of political or other interests creating risky or irrational outcomes
- HMI has acknowledged that collective bargaining alone may not yield the desired cost-effective quality outcomes

5 Any intervention must lead to clear benefits which outweigh risks to competition and innovation



Price regulation will not address the problem of high claims inflation

Average annualised inflation rates (2008 -2016)



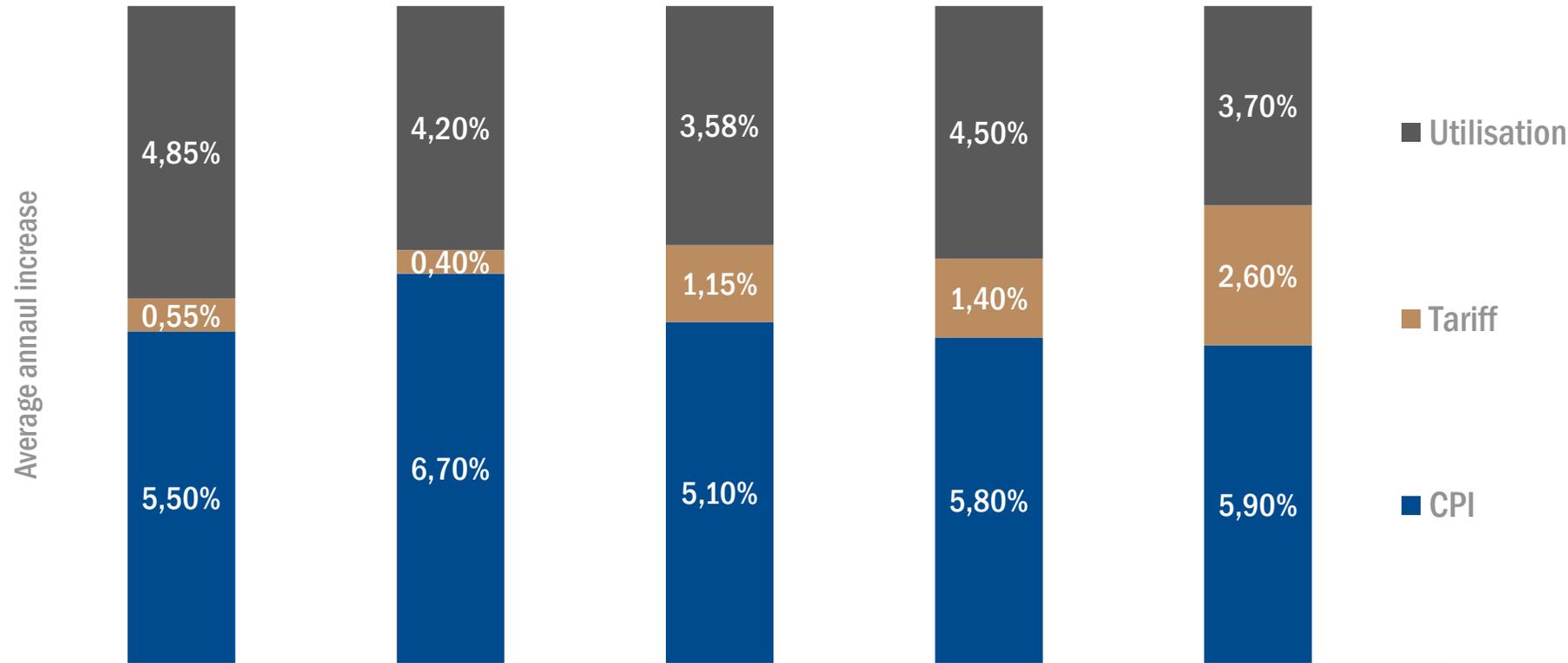
If tariff differential was 0%, since 2008, premiums would be **3.5%** lower

If utilisation was constant since 2008, premiums would be **29%** lower



Stakeholder data confirms utilisation as the major driver of gap between CPI and premium inflation

Cause of average annual inflationary increase



- **No dissenting views** on utilisation as key cause of medical inflation
- DH data: more than 2/3rds of utilisation is due to **anti-selection** and **demographic** changes



2013



2008-2013



2010-2013



2000-2013



2000-2010

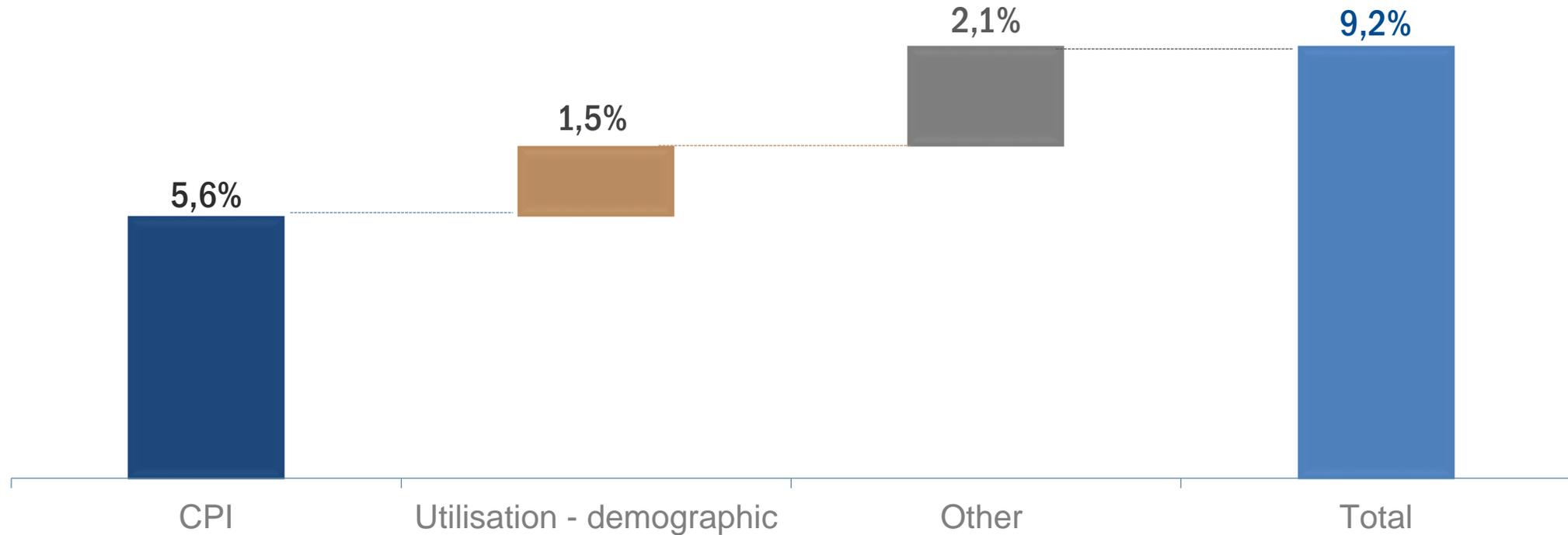
Source: Summary of data received by the Commission

Note: * Figures from Medscheme were estimated assuming the residual impact was split 50:50 between tariff and utilisation



HMI has acknowledged that claims inflation is driven by a myriad of factors, not just price

HMI Claim inflation trends (2011-2014)

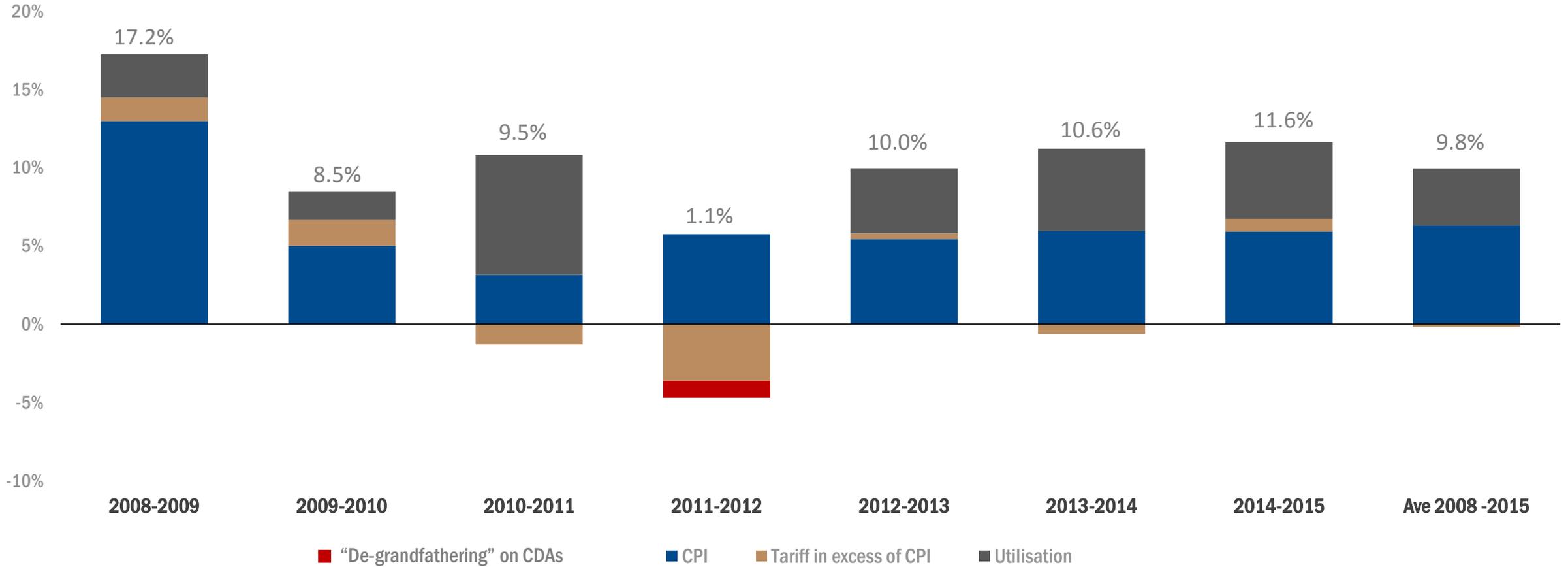


Source: HMI Attribution analysis



Experience from Single Exit Price: Medicine claims inflation remains high despite price regulation

Medicine claims inflation (2008 – 2015)



Source: DHMS data



Existing bilateral negotiation processes have several advantages

Promotes competition between providers

- Hospitals compete for network inclusion, and network plans significantly more affordable
- Drives hospital efficiency
- Individual providers compete for volume by participating in network arrangements

Promotes competition between medical scheme administrators

- More effective tariff negotiation and related product design increases competitive advantage in market for administration contracts

Promotes competition between open medical schemes

- Achieving lower tariffs results in more competitive premiums

Promotes innovation in procurement/contracting

- Investment in alternative reimbursement strategies
- Value based contracting
- Increased provider efficiency – lower costs and improved quality of care



A shift to coordinated bargaining or price regulation will create significant risks

Reduced competition due to supplier coordination/collusion

- Effectively legitimise price collusion in already concentrated hospital and pathology markets
- Economic theory and evidence are clear that supplier coordination is more harmful, and more consistently harmful, than coordination on the buyer side
- No reason to believe collective bargaining would result in lower overall prices, nor address issues of cost effectiveness and quality of care

Reduced competition and reduced incentives for innovation

- By schemes/administrators in procurement, cost containment and network design
- By providers in cost and quality improvements
- No player will derive relative benefit from more innovative or strategic contracting, and hence it is less likely to be attempted in the market

Potential for poor governance and/or lack of technical capability

- Risks of political or other interests and/or corruption creating risky or irrational outcomes



Recommendations

1

A collective coordination process should be developed between funders and all providers for the updating and maintenance of billing codes

- Should be exempted from competition law constraints
- Process controlled by market players, with recourse to independent, technical adjudication tribunal only for deadlock breaking
- Process should apply to codes, descriptors and the relative value unit of codes, but not the tariffs associated with the codes



Recommendations

2 Coordinated bargaining process for individual health professionals and funders

- Should be exempted from competition law constraints
- Process controlled by market players, with recourse to independent, technical adjudication tribunal only for deadlock breaking
- Independent, technically skilled arbitration body to undertake research aimed at assisting the parties and to break deadlock
- Arbitration body should not be appointed by or be accountable to government or regulatory bodies, nor any other interested parties to avoid interference and undue influence
- Consider independent, trusted inputs into bargaining process
 - Rigorous, independently conducted provider cost and profitability studies
 - Independent annual cost and utilization increase index
- Resulting tariffs should be used a maximum tariffs for PMB codes (in absence of agreement) and as reference tariffs for non-PMB codes.
 - For PMB codes, maximum tariff is the default in absence of agreement on tariffs between scheme and provider.
 - For non PMB codes – allow parties to negotiate bilaterally, with reference to the collectively determined codes
 - Critical for parties to be able to agree to pay higher or lower than negotiated tariffs



Recommendations

3 Retain market driven, bilateral negotiation process for corporate providers including hospitals and pathology laboratories

- Must remain subject to competition
- Allows pro-competitive outcomes in markets for schemes, administrators and providers
- Fosters ongoing innovation
- Market intervention should not be aimed at protecting smaller schemes or administrators at the cost of competition – this will ultimately harm the majority of consumers through encouraging supplier coordination



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